Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be reimbursement of $264.00 for date of service 01/07/02.

   b. The request was received on 06/03/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60
   b. HCFA
   c. TWCC 62 forms
   d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   a. TWCC 60
   b. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. The Requestor did not respond to the Request for Additional Information as required per Rule 133.307 (g) (3). Therefore, no additional documentation was forwarded to the Carrier Per Rule 133.307 (g) (4).

III. PARTIES' POSITIONS

1. Requestor: The Provider did not submit a position statement.

2. Respondent: The Carrier did not submit a position statement.

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 01/07/02.

2. The denials listed on the EOB are “D-Duplicate Charge. N72-Not Documented. Documentation must include treatment provided (with days of week), response to treatment, progressive overall improvement of symptoms; failure to respond to treatment

should reflect a change of the treatment plan. O-Upon review of your request for a reconsideration, no additional benefits is recommended at this time. F-Reduction According to Fee Guidelines."

3. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MAR$ (Maximum Allowable Reimbursement)	REFERENCE	RATIONALE:
01/07/02	97124	$70.00	$0.00	D,N,O	$28.00 (each 15 minutes)	MFG MGR (I)(A)(10) CPT descriptor	The provider did not submit medical documentation to support the services rendered. Therefore, reimbursement is not recommended.
01/07/02	97113	$224.00	$0.00	D,N,O	$52.00 (each 15 minutes)	MFG MGR (I)(A)(10) CPT descriptor	The provider did not submit medical documentation to support the services rendered. Therefore, reimbursement is not recommended.
Totals		$294.00	$0.00				The Requestor **is not** entitled to reimbursement.

The above Findings and Decision are hereby issued this 31st day of October 2002.

Michael Bucklin
Medical Dispute Resolution Officer
Medical Review Division